Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health

Respondent Name
Memic Indemnity Co

MFDR Tracking Number
M4-13-2466-02

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 28, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was referred by her treating physician, Tuan Trinh, DO. The services were provided and the claims were recommended an allowance but payment was never received."

Amount in Dispute: $675.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 3 – 19, 2012 and January 7-21, 2013	90806, 96151, 90882	$675.78	$430.56

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 790 – This charge was reimbursed in accordance to the Texas medical fee guidelines.
   - W1 – Workers Compensation Jurisdictional Fee Schedule Adjustment.

Issues

1. Did the respondent support payment have been made?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent stated in their position statement, "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines." No documentation was found to support this statement. Therefore, per 28 Texas Administrative Code §134.203(c) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications." "(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is current year conversion factor." The Maximum Allowable Reimbursement will be calculated as follows;

Date of Service	Submitted Code	Submitted Amount	Allowable	Amount paid	Amount due
December 3, 2012	90806	$145.00	2012 DWC Conversion Factor / Medicare Conversion Factor x Non-Facility Price or 54.86/34.0376 x 82.48 = $132.94	0.00	$132.94
December 10, 2012	90806	$145.00	2012 DWC Conversion Factor / Medicare Conversion Factor x Non-Facility Price or 54.86/34.0376 x 82.48 = $132.94	0.00	$132.94
December 19, 2012	90806	$145.00	2012 DWC Conversion Factor / Medicare Conversion Factor x Non-Facility Price or 54.86/34.0376 x 82.48 = $132.94	0.00	$132.94
January 7, 2013	96151	$140.00	2013 DWC Conversion Factor / Medicare Conversion Factor x Non-Facility Price or 55.3 / 34.023 x $19.53 = $31.74	0.00	$31.74
January 21, 2013	90882	$150.00	Not covered by Medicare	n/a	n/a
	Total	$725.00			$430.56

2. Based on the above, the maximum allowable reimbursement is $430.56. The carrier previously paid $0.00. A payment in the amount of $430.56 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount recommended is $430.56.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $430.56 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 21, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.